TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
HOUSTON HOSPITAL FOR SPECIALIZED SURGERY

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-15-0117-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
September 09, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "For the services received at Houston for Specialized Surgery on 06/27/2014, we have billed your employers' work compensation insurance plan Texas Mutual; however, we have received a denial of coverage. The services were denied due to Texas Mutual deeming the services for needing precertification/authorization prior to services being rendered. Never the less, we are appealing the denial on your behalf with Texas Department of Insurance as services being medically necessary due to being a medical emergency. The appeal we will be filing will consist of a Letter of Appeal that presents a general argument that the services provided were a medical emergency therefore should be covered under the worker compensation insurance plans benefit."

Amount in Dispute: $33,986.70

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 6/27/14. The documentation from the requestor on 6/27/14 states, "The patient has requested that a surgical procedure be performed. This was selected by the patient from among other options including the option of non-surgical management of the problem… Texas Mutual understands that a medical emergency would be the only option on the table not one among other options. Further, the fact of other options means the claimant elected to take the surgical one. The failure in the documentation is that it does not substantiate how, once the surgical option was selected, it now became a medical emergency obviating the requirement of preauthorization."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 27, 2014	Outpatient Hospital Service	$33,986.70	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the procedure for preauthorization, concurrent utilization review, and voluntary certification of health care.
3. 28 Texas Administrative Code §133.2 sets out the general rules for medical billing and processing.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-P12 – Workers Compensation Jurisdictional fee schedule adjustment
   - CAC-16 – Claim/service lacks information or has submission/billing error(s). Which is needed for adjudication
   - CAC-197 – Precertification/authorization/notification absent
   - CAC-97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 217 – The value of this procedure is included in the value of another procedure performed on this date
   - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information
   - 305 – The implant is included in this billing and is reimbursed at the higher percentage calculation
   - 786 – Denied for lack of preauthorization or preauthorization denial in accordance with the network contract
   - CAC-W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
   - 724 – No additional payment after a reconsideration of services. For information call 1-800-937-6824

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code CAC-P12 – "Workers Compensation Jurisdictional fee schedule adjustment", CAC-16 – "Claim service lacks information or has submission/billing error(s). Which is needed for adjudication", CAC-197 – "Precertification/authorization/notification absent", 217 – "The value of this procedure is included in the value of another procedure performed on this date", 225 – "The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information" 305 – "The implant is included in this billing and is reimbursed at the higher percentage calculation", 786 – "Denied for lack of preauthorization or preauthorization denial in accordance with the network contract", CAC-W3 – "In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal ", CAC-193 – "Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly ", 350 – "In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal " and 724 - "No additional payment after a reconsideration of services. For information call 1-800-937-6824."

   28 Texas Administrative Code §134.600(c) states in pertinent part "The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this

section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions)."

28 Texas Administrative Code §133.2(5) states: "Emergency--Either a medical or mental health emergency as follows: (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or(ii) serious dysfunction of any body organ or part; (B) a mental health emergency is a condition that could reasonably be expected to present danger to the person experiencing the mental health condition or another person."

Review of the submitted information finds the documentation provided by the requestor states "The Patient has requested that a surgical procedure be performed. This was selected by the patient from among other options including the option of non-surgical management of the problem. The patient has voiced understanding that surgery comes associated with numerous potential risks that have been reviewed today." Therefore, the documentation provided does not support emergency care in accordance with 28 Texas Administrative Code §133.2. The insurance carrier denial reason is supported. Additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		7/10/15
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.